**NHS Education for Scotland**

**Transcript of 'Supporting people who are Bereaved in Primary Care' (NES Bereavement Webinar, 2022) video.**

**Chair**: Dr Graham Whyte, Associate Postgraduate Dean for Grief & Bereavement, NHS Education for Scotland.

**Speakers**:

- Rebecca Adams, CCL Listening Service Coordinator, NHS Tayside
- Muriel Knox, CCL Listener, NHS Tayside
- Dr Sarah Luty, GP and Associate Advisor, NHS Education for Scotland
- Vicki Waqa, GPN National Coordinator, NHS Education for Scotland

**Graham Whyte (GW):** Well, good afternoon, everybody and my name is Graham White. I'm one of the associate postgraduate Deans with NHS Education for Scotland and also consultants in palliative medicine at Marie Curie Hospice in Glasgow, which cheating this lunchtime session.

So now I would like to welcome you to the, you know the 17th Bereavement webinar in our series and today's session is entitled supporting people who are believed in primary care.

And very much like to welcome our speakers as we go for great speakers for you this afternoon. Rebecca Adams is the coordinator for the community chaplaincy listening service in Tayside.We've got Muriel Knox, who's retired healthcare chaplain living in Aberdeen. Muriel's worked mainly in mental health and now trains people for the community chaplaincy listening service and also helps deliver that service seriously. Sarah Luty is a GP and also associate advisor with NHS Education for Scotland and dealing with matters of patient safety and quality improvement. And last but no means least, we've got Vicky Waqa who is a general practice nurse, national coordinator for this and in former roles, as an advanced nurse practitioner in primary care and a senior charge nurse and A&E in London.

So welcome to all our speakers today just to give you a bit of an idea as to how today's sessions going to work. It's kind of split into two halves, so we're going to have a 20 minute presentation. From Rebecca and Muriel, and then the second half of the session will be handed over to Sarah and Vicky to have a kind of conversation about bereavement within primary care and hopefully the end will then have an opportunity for questions and have a bit of a Q&A session at the end, so I think that's it for me and I'll hand you over to Rebecca, I think it's going to kick us off and hope you enjoyed today's session.

**Rebecca Adams (RA):** Thanks very much Graham. It's great to be here and thanks also to Muriel as well who is joining us from NHS Grampian I hope that lends itself to as an example actually of how CL community chaplaincy listening is a consistent practice across the whole of Scotland, where it exists.

And so, although I'm in Tayside and Muriel is in Grampian, there is a huge amount of mirroring and consistency across the practice as well. So, thanks for so much for joining us and Muriel.

So first of all, just to set the context of why CCL exists in the 1st place. So, I just let you can consider a few things. For a moment you don't need to write anything down to just hold on to the thoughts for a moment so. I guess just looking at grief from and the experience of loss from a wider context initially than just bereavement. So, I'm wondering what loss there's been over the last two years.

The last five years. For you, for your family, maybe a loss of work, loss of health, relationships, perhaps the loss of a sense of security on safety or security. A loss of freedom. And perhaps the loss of meaning or hope for some people, and so just consider for a moment the various different types of losses and wonder if you felt that when a new loss occurs, it might throw open the drawers of many of the other losses or bereavements you may have experienced in the past.

And I also wonder whether or not there was anything that perhaps surprised you about how you felt, not just emotionally, but perhaps also physically as well. When you experience that loss, and perhaps it brought home the realisation that there are as many different ways to grieve as there are human beings on the planet. So just consider your own experience for a moment before we look at you as healthcare professionals and kind of next, I guess, consider what got you through perhaps who got you through, what kept you going, what perhaps still keeps you going.

And what those things were and maybe again, some of those things might surprise you about what, was that was, your support through that time and continues to be perhaps. And so. Then as we start to think about you as health and social care professionals, I'm wondering how you feel when you are faced with somebody else's grief through your work. Do you have maybe a strong desire to fix it? Or maybe you feel that you lack the tools to do so? And those of you that perhaps are able to prescribe medication? Do you feel an urge to do that? Do you worry that if you open the doorway to their grief and loss that it might be difficult to close? That door again, and from that, what are the pressures around you? What are the clinical pressures? The time pressures that you have around you? When you're faced with somebody else's grief in that moment, and so all of these things that that that you're thinking about. All of those things in your head.

This is an example of the context of why CCL was set up, and so again, it's not just about bereavement. It's not even just about loss, but it's for any challenging experience that somebody is going through this could be work related, stress, difficult relationships, chronic illness. It could be carrying responsibilities. So, what community chaplaincy listening does is? It provides a 45–50-minute space to talk and be heard by someone with buckets of empathy. Plenty of training and support, and a lot of self-awareness.

But it also is provided by someone who doesn't have any of the clinical or time pressures that may surround you. And so, if you've ever felt truly listened to without interruption, without advice, without judgment, you'll know how affirming and restorative that can feel. And so, as well as listen, what we do is we also encourage, and we help to draw out what may be a source of support for people. So we recently collected evidence as part of a patient reported outcome measure and the people who responded said that they felt less anxious after CCL.

They felt more in control more at peace and for some. CCL is the time where they have, maybe the first opportunity to be really honest with themselves about how they're really feeling. Sometimes it's the first time they've talked to anybody at all about a particular subject, so being a CCL listener is honestly a privilege, and the listeners in Scotland are made up of experienced staff and volunteers, so you'll need Muriel in a moment.

There's also like I said, there's a consistency across the boards that provide it, so there's a national formational training program, and no matter what somebody's background of work or life, they are all given the same task in the same boundaries. Our volunteer listeners or our staff listeners are mainly chaplains or CCL coordinators, but our volunteer listeners are made up of a variety of might be healthcare staff, some nurses and doctors, HP's, some might have a counselling or a psychology background. Some might have a spiritual care background, but many have just brought with them their experience of life and a willingness to donate their time and energy. And it's such a privilege to work with an amazing group of people.

Unfortunately, I will say at this point in time that the service is not provided across Scotland and every board area, and it's provided by slightly different group of people in some board areas. Although everyone's trained the same, there's a kind of, there's not a continuity of availability of the service, so some of you may be aware that it's present in your GP practice, either where you work or where you're a patient.

Others may never a part of the service, so I would encourage you to investigate whether or not it's available. If you'd like to know more about the status in your board area, please do get in touch with your NHS boards, department of Spiritual Care, which is where CCL's home is. The main issue is financial resources to support, so there might be conversations around that, but I would encourage you to investigate whether or not it's available in your area.

So, I would like to introduce Muriel as well. I don't know if you're muted. Muriel is your microphone on.

**Muriel Knox (MK):** I think it's on.

**RA:** is it perfect? So first of all, if you could just say, say, a little bit about your background before you became a listener with CC, that would be good to come.

**MK:** Well, I am a trained counsellor, but really, I was I came into CCL through chaplaincy because I was the lead chaplain at the psychiatric hospital in Aberdeen for a number of years, and then when I retired, I wanted to continue to do to use some of the tools I'd learn. So that's why I'm in CCL.

**RA:** Our friends, that's fantastic and what is your description of their formational training? What's involved in the training that that you have to go through with.

**MK:** the training I've just finished yesterday and new cohort of training and. The training consists of eight half day sessions usually condensed into four full days. And we're not training people to listen.

We kind of take that as a given that that the people who come on our training and have already listened in their line of work or have done some sort of listening training. We're training them to listen in a specific way and training them for specific areas. And of course, bereavement is one of them, and that I hope we spend 1/2-day session on that, and we spend some time looking at mental health and the kind of listening we do is called its spiritual listening, but it's called asset, assets-based listening. And when I say spiritual, I should say not religious. We make that quite clear and we're not there as representatives of any particular religion where there just to listen to people, if people bring up religion, of course that's their right and we will talk to them with about that. But that's not in the agenda. So, what we're looking really at what people's resources are helping them to identify what gets them through, what gets them up in the morning? What help? What's helped in the past, and what can help now. And trying to identify that with them and just journey with them, really. And listen to them.

**RA:** Yeah, perfect and did you say a little bit about the triads as well, which is the kind of core part of the training?

**MK:** Yes, the training is very experiential, and a lot of the training is spent in triads, and I'm sure most of you know what that is and we have one listener, one speaker and one observer, and they rotate and so everyone has a chance to listen.

And that's really an important part of it because. They ask people to make themselves vulnerable and to really share quite deep things about themselves so that they have the experience of being listened to, and then the listener obviously is practicing the listening skills and the observers watching what they're doing, writing it all down for them, which can be very daunting.

But people get through it, get used to it, but it's a very important part of the training.

**RA:** Yeah, it's fantastic and it's such, it's a really good experience even if people don't proceed on to become a listener. It's a very.

Exactly, intense and very rewarding process to go through the training. Great so when you when you become a listener, what kind of support and do you get once you become a listener?

**MK:** OK, well we have supervision for all our listeners and there's a minimum of four sessions a year of supervision. I'm a trained supervisor as well, and we also have to use the jargon VBRP if you don't know where that is, its values based reflective practice, which is really like a kind of group supervision because we have a facilitator and other listeners who are sharing their experience. So, there's quite a lot of support and there are in Aberdeen. I don't know about everybody else, but we've got a couple of coordinators in Aberdeen, so there's always somebody to talk to if you're having difficulties with your listening or practical difficulties in the surgery where you're working and things like that, that's not really the listener's job. To sort that out, that's somebody else's job, and there's always somebody on hand to help with that.

But there is, there's a good back. There is good support, and there's also. Not. There haven't been for the last couple of years obviously, but there is a national gathering sometimes, so we can all get together and share our experiences.

**RA:** Perfect thank you and so just moving on to bereavement specifically so you mentioned a little bit about that already, but if you if you could say a bit more about bereavement and losses of future of kind of CCL appointments that you've been listening for, but also describe what your role is when somebody wants to express their grief within that context.

**MK:** I think the thing about bereavement and grief is that it can be. It can be in the present here and now. It can have happened just quite recently, or it can have been reawakened because of some trigger. And be something that perhaps has been hidden for a while and comes to the surface. I think one of the positive things about CCL is that there isn't usually a waiting list. So, whereas with some of the other services you know you have to wait quite a long time to talk to someone, usually at CCL you can get in quite quickly.

And. It's important to see what we're not. We're not therapists. We're listeners and that should be quite important, and I think quite often that's a very positive thing because for people they don't feel that they need counselling or psychiatric help or anything like that. They just want somebody to talk to. And when I was younger, I was brought up in the top of a tenement and some of you may know what that is like, but there was a great fellowship and community, and when someone died there was somebody there for everyone. You know, we could all talk about it together.

That doesn't really happen very much now. And so just the sheer ability to talk and go over the same kind of thing. Often you want to tell the story again and again and again until you are beginning to learn to live with it, so I think that's a great benefit of CCL. As you've already said, loss comes in all forms, but the actual experience of losing a loved one and death is a huge part of CCL and also, and I'm just thinking of something that happened to me. I was just at the surgery one day and one of the doctors knocked on the door and said, how can you see this man for me, and any came, and he was an unknown awful state and just two days before he'd found his son had hung himself and he trained his body and but there was nothing much to do with him except just be beside him give him space and be another companion with them to share his grief. So, you know it can be instant like that as well.

**RA:** Yeah, thanks so much Muriel that's really illustrative of what can come in the door. Any point, and we don't we don't have any information, so we don't read patient notes. You know before someone comes and we just have their name, occasionally their date of birth. So, it really can be anything.

And often bereavement and grief and loss doesn't come in a vacuum in somebody's life. It can be surrounded by maybe financial worries on difficult relationships at home stress work so often it's a single layer within other layers that are coming in. For them at that time and with us not being specifically a bereavement service, it allows the opportunity for somebody to talk about some of the other things that are also going on in the context of that grief as well as, you know, instead of just purely focusing on the bereavement.

And I lost what we do, I think you found this as well. Muriel is that kind of sense of reassuring people that what they're experiencing is understandable and a very natural process that they're going through. I don't like the word normal. I prefer to use the word understandable or natural because normal is not normal. For them, they're not feeling OK. They're not feeling normal for them, so understandable or natural. I think it's just a bit of reassurance, I think, as well that they're not doing it wrong or incorrectly, or they're not going mad.

**MK:** And we've got some illustrations that we can use with people, and some of you may have seen the photo pool of grief or things like that help to show people that a lot of people go through the same kind of experiences. As you say, normal are funny sort of word, but it's. Yeah, it's a common experience to feel guilt, to feel, and sometimes she feels relief even because that that's something that people are almost afraid to express, but nevertheless it can be there. So there are all sorts of things can be told and that confidential.

**RA:** Yeah, absolutely, and that safety when you're not a friend or family member to be able to express some of those things as well.

Thank you so much, Muriel. That's our time. And yeah, they'll be QA after this. But also, I think there'll be other further questions. Being able to be emailed around to us as well, so any other questions anyone has about CCL, and happy to. I'm happy to answer them. Thanks so much.

**GW**: No, thank you very much Rebecca, Muriel that was really insightful here. Some understanding CCL, but that certainly crystallized things a lot better for me and so I very much had the focus of it on more on bereavement. So, it was interesting to hear how certainly is much, much wider than that. So that's really helpful to know something. And as I say that encourage you to post some questions in the chat and we'll get an opportunity to answer them later on. So, thanks again.

And so, we'll now move on to the second half of the session so, and I'll welcome Vicky and Sarah to have a conversation about supporting people who believed in primary care.

Thank you.

**Sarah Luty:** thank you.

**Vicki Waqa:** thank you so that was great. Actually, I was writing some things down in the one thing that stuck in my head Muriel was journey with people that just thought how powerful a statement. That is because that is really what you do for people. So, thanks for sharing that. Sarah I've got some just a few questions for you, so suppose it's a GP and probably in quite a small practice you don't have any. A nice community practices. Maybe it's a better word to see how. How do you support people in primary care who are bereaved or grieving?

**SL:** I'm going to echo that I wrote down journey with people as well and I think I think to me that's what being a GP is. That's my primary role is, that journey with people through all, all that they share with us and they sort of the traditional model or the viewpoint of what primary care is, it's comprehensive care first point of contact, continuous care and coordinated care so that is journeying with somebody throughout their whole life.

So, when I was asked to this webinar a few months ago now I started to pay attention to my consultations. And I started to just keep a wee 5 bar gate of how many, bereavement or grief showed itself in our in our consultations and it is remarkably common. It is remarkably common how often it comes up, and it comes up just as Rebecca was saying about new losses opening the drawer on old losses. And, just as Maria was saying about grief, can be here in the here and now, or it can be awakened at other times.

And I think. An example of that we tell a story if that's OK. I am about the day or so after I was asked to do this webinar. I was on triage, and I took a phone call for somebody that had diarrhoea and had had vomited a few times. And if phoned her and had to make the decision if she had a GI bleed so that a very acute general practice type of consultation. I looked through her notes and she had the notes that you can imagine the tone of this. She had denied excessive drinking she had denied, drinking at numerous occasions and fit to drive that these sorts of sentences were in the notes and I didn't think anything of it because I was too an acute piece of work.

So, she was brought up for me to do a pulse. No food pressure equilibrium. And when she came in from the waiting room, I recognised her. I recognised her face, didn't recognise her name. She wasn't known to me at all, but I recognised her face. So, when she came in, I did this sort of opening of and. And how are you? And her sentence was, ah, it's been six years, Doctor.

So, she's in for an assessment of has she had a stomach bleed or not and her opening sentence with me was that's been six years and had looked after her husband who had died. And this was our first our first contact since that acute grief and bereavement. So, she sat down and started talking about the days being long and there not being much focus to them and she was drinking a little bit more than normal and she hadn’t told her family. She was a wee bit ashamed about that. And she had to go into hospital for a GI bleed and in the notes they wrote. These women who has struggled since the death of her husband, has [been] drinking excessively and now has health consequences of that. And in the hospital, she was treated with utter compassion, from having had previous, in and out hospital admissions with the same thing.

And she was treated with compassion, and she met the alcohol link worker, and she came home on a slightly different path. And I think. I think I would have always had that consultation, but I probably

wouldn't have framed it quite as much in the, this was unresolved grief, and this was a bereavement reaction that that that showed itself in our normal general practice setting. And I think that. When I count the number of times that people will hearken back to loss and it would be said, and just as Muriel was saying, don't want it fixed, they don't want it taken away, but. They just bring it, they just bring it into the space of the consultation and that's our privilege because that that's part of what we do.

Thanks, Sarah, I think a lot of that goes back to us as well. Wouldn't be fixers, isn't it? We think we're not doing anything by listening, and it's the most powerful thing that we can do. And I've learned that as well. And now I've got a thing as you know about language so that's amazing. By reframing that just that, the empathy and the compassion that's really powerful, really powerful. I'm sharing that. So, thank you.

**SL:** I think so. I think you're right about that language, the difference of. You know, hasn't done what she's told to understand that she's lost, that she feels lost. It's a very different, very different sentence.

**VW:** very. And what? What about Kenny? Like, if we're thinking of sudden or unexpected deaths is that different maybe? And how we go about dealing with that or approaching that?

**SL:** Absolutely. And then there's the sort of phrase of good death, good grief, and when you're involved in the end-of-life care and with a patient that you've known for a long time, you know the family. You know, I don't really get involved in grief work at all, because a lot of that is, and it's been dealt with in the anticipatory period. A sudden death is a very different ball game, and part of that is your role as a doctor comes into question there.

Why did this person die was, oh my goodness, who saw them last? Because that's, you know that's there in your thoughts and. And also, you know Rebecca was talking about the pressures that you feel as a health professional and that strikes a chord. If you arrive and you work at 8:00 o'clock in the morning and the police are there because somebody's been found or your junior doctor was the last person to see them, and they didn't think that this was a path that they were, that they were on it, and that wasn't the trajectory of their disease. Or the receptionists have taken the call and the patient has said they didn't need a home visit and I don't want to bother them. I know they're really busy. It'll be fine tomorrow when I can get a lift down or, and we underestimate that, we underestimate, that is, that's a big deal. That's a big thing for, us not just healthcare clinicians, but the whole staff deals with that in different ways and. And Muriel mentioned suicide there that's a burden of guilt you want to make sure that you had done everything that you could and if you'd seen them so sudden deaths have a very different feel in primary care, and I think it's. It is in. I don't think it's to do with being a small practice. I think it's to do with all practices. Who takes the phone calls? Who's? Who's dealt with that? And you just feel their energy and the room and the tension being slightly higher.

**VW:** Yeah, just before you even said the police been in the building at 8:00 in the morning. That was exactly the thought I had, and I haven't asked you these questions before, but that was exact feeling I had and it's that relief that you weren't the last clinician to see them. But then how do you support that the last person to see them or speak to them? And yeah, it's really different.

**SL:** We had one recently that it just it just grew arms and legs because it was a person had been found in by their teenage neighbour. And the teenage neighbour had called the ambulance and the police and all of those things. And the police came to us to sort of identify next to the kin. And those sorts of things and. You start to go OK, what am I dealing with here? Who who's the teenage

neighbour? Is he one of ours? Is he OK? And for each is what age is the teenager? Is this an expected or unexpected event? And who's in that person's life? And there any of our staff in that person's life? And you remember this from A&E days if. If a person, an incoming patient, was known to one of the staff, you were able to sweep them away and protect them a little bit and in primary care, you can't really predict who's coming in on the phone or what's going to happen. So, if this is somebody that is, is known or is going to have an impact on one of your team is, it's important that we that we get it, right who's in this person's life? What's their sort of circle of support? Can you ask me to become into the practice today for a routine blood pressure check and they find out that there's? There's police there's about somebody that's died, so it's trying to get who that person is or was in their life and who, who's all involved in that.

**VW:** How do you go about doing that?

**SL:** So when it's one of us and it's the who was the last person to see them alive. And it's an unexpected death. As a partnership, we don't do that ourselves, so we have. You have the look to go. Who was it and then? I would look on behalf of my partner and say let's have a look.You saw them yesterday. What was your assessment of? because when you when you look through your own records with the hindsight bias of what has happened, you look, and you appraise yourself very critically. So as a partnership we do that for each other and for our journey junior doctors their supervisor would do that. They would go ok. This is an unexpected thing. That's another, and there's quite a lot of tea involved, and that's quite a lot of tea and quite a lot of sorts of make space for this. You're going to have to answer a phone call in a very short time, are you going to issue the death certificate. Is there any suspicious circumstances, and you have to know what you're thinking. You have to have clear logical thoughts about it. When it's something like a patient that the receptionist might have been involved in or somebody that's well known their team and they're obviously not family, but well liked, you know part of that. It's like the old encore that comes with for. We make sure that we know who needs to be told so they don't find out and you know the idea of, that person's relative coming in a couple of days or weeks later, and one of your staff not knowing.

So, we have a board that we write deaths on, and we have we. We actually physically draw a circle around that. Who's involved? Who knows who's yet? To find out. You know, we'll have to make sure if you want to find out before she comes back from her district nurse. So and so is on holiday will have to make sure because they are likely to meet people.

And just because there's nothing worse than getting caught out and being kind of. Suddenly caught unawares or distressed by something and a bit like Rebecca was saying about new losses and all the losses. If one of our staff has had a particularly traumatic event in life.

So, if it was one of our staff that had experienced the loss of a loved one with suicide or something. I wouldn't want. I would want them to know and then a careful and planned way. If something had happened in the practice so they didn't find out. You know or that's you know so and so. Didn't something happen that they would? They would have the space to deal with that as opposed to finding out from a patient.

So just. So, there's a lot to think about.

**VW:** Just yeah, just tell you so. Thinking of that full team and the impact on the team, the family, the community in that real, relational, compassionate care, isn't it so. But my question, can he be about like do you think it is different with being in that smaller? Kind of community environment? But you've maybe answered.

**SL:** I don't think it is. I think I think what we have to think is health professionals, and especially in general practice and primary care is that. When we're wobbling when we're not fit because of our own grief or our own shock and despair of something we're not fit to be good at our jobs and so and that's all of us and somebody on my front desk answering the phone that's had a bit of a, oh my goodness, you know that was me I didn't put that on visit in or that's a suicide.

And that reminds me of…They have to deal with whatever happens next, so if that's an angry patient or a distressed patient, or they've got to be fit for that and they've got to be in the right space. And in order to do that we have to have who they are in this moment in time, discussed and it doesn't take long, it just takes the awareness that that might be needed. Then it you know it may just be are ok, do you need time off the desk? Do you want me to put the kettle on? And that might be all it takes, or it might be. This, has this situation has made me is opened up that loss again and I'm not fit. Could you see that patient for me? I'm not going to be able to do that well. That's my job. That's what we should be able to do so that our patients get the best of us.

**VW:** Spoke to that enabling that conversation, though it's that language as the ticket I'm thinking is that a big formal process, and do you need to sit down with your full team? And how do you do this? But you're just saying that it's just are you alright. Do you think away from the desk? It's just being thoughtful and kind, isn't it?

**SL:** And also knowing your team, know that so that. If having a kind of culture in the organisation that they're allowed to see, I'm not so good you know. And you really experienced a terrible event many years ago where one of our staff lost their son. And it, if we'd had the community with listening service really, if we, if we could have access that that would have been great. And because none of us, really knew what to do and we had. I went to her house with, and you can imagine anybody that works from here. Can imagine this. I went to her house with. The collection of mugs. Because I thought she's going to have lots of visitors, and we took tea bags, and we took you all these things that that she might need. Because when I arrived the staff had put all their stuff together and still makes us all laugh that she had, you know HRT branded mugs that she's giving out in her home, and I and she just saw that as being we're all in. Where the team is all in. This is terrible and we don't know what to do, but we're here and but it's how do you? How do you make the organisational culture? And set you know how? How do you get people don't want to talk about their problems at their work and? And often, we get into that fixit mode and they and they. No, it's OK. I need to be in my work. And. I'll be alright and better here. They need to keep busy and that's fine. That's absolutely fine. If you are OK, but. The next person coming in through that door needs your full attention and you have to be able to do it.

**VW:** I'm going to write that line down as we have the next person coming in your door. That's really powerful too. I'm aware of time, and I know how you and I both like to talk, so I don't know if there's anything else that you wanted to you wanted to say Sarah.

**SL:** No, I think I think it's just such a privilege. It's such a privilege to do that journey with people you know to journey along with them, and loss is such a huge part of it. For many, many people and I see it as being the core business of the primary care team.

**VW:** Thank you, Sarah, thank you.

**GW**: Oh, thank you very much, Sarah and Vicki. That was really nice to listen to and certainly pick up a few tips there. And I think we've been talking recently. Just about the kind of bereavement friendly workplace almost. And how do you create that culture? Certainly listening to how you've done that within your practice. And let's say that ripple effect almost of grief and how it can affect all those

numbers of different people. And just as how you have that awareness. And you need to start in the place and talk about it, don't you? To actually enable that. So that was really interesting and powerful to hear some of your thoughts on that. So, thank you very much. So, I think I'd like to invite Muriel and Rebecca back as well, I think, and we can maybe open the open the floor to questions if anyone. And please want any questions. Post them in the in the question box on the right-hand side of your screen and I think. Just why the first starting? I suppose it was just. When listening to Rebecca Muriel, suppose it was more. I was thinking in terms of. How about how do people go about dispose referring to the service that has? If they think somebody might benefit from, how do you find out if it is available in your area? Or how do you? And if you wanted to refer somebody, how do you actually do that? As oppose? I don't know if you're able to answer that.

**RA:** Yeah, so the vast majority of our referrals are GP's picking up on somebody's need to talk and the GP's will either depending on their system, will either put them directly into their appointment system within the practice, or it might be that on the way out the personal booking it reception.

But we're increasingly getting referrals from elsewhere now in Tayside. So, in Tayside we accept self-referrals. We have a central phone number where people can book in with us and have a phone appointment if there's not a face-to-face listener available in their practice.

And also, we're getting increasing referrals from other areas of the organisation as well. So, from acute as well. People are being discharged from acute pain clinic referrals. We have worked quite closely with the AHP team in supporting people with long COVID as well, so there's it's. It's not, it doesn't just need to be a primary care model that can fit with all kinds of different sections of the NHS's work and with referral some other clinicians. So, in short, anyone can refer themselves in, to CCL, but still a lot of people will not self-identify themselves as needing the service. It often will take a clinician to suggest it to them and say look, we have the service available. It sounds like it might be helpful for you to have a chat with someone.

Here's the service and then that really can give somebody the confidence and the boost that they need to make an appointment as opposed to them seeing a leaflet and then thinking that that's something that would work for them. We do get a few people like that, but it's. It's less common.

**GW**: No thank you for that. We do have one question here related to the CCL and someone possibly interested in terms of how we'd actually go about applying to be a trainer then. Or sorry to be trained to. So, if you're interested in volunteering, who would you get in touch with as opposed.

**MK:** I guess you would get in touch with the Chaplaincy department of your Health board, and they would be able to tell you that. We certainly have just. We've just been recruiting and NHS Grampian and, I've got another cohort coming up in July and August. We've still got open places there if anybody's interested in that, but that would depend on where you live.

**GW**: No thank you for that and. Sticking with a CCL theme, I think can anybody refer to set can practice nurses refer? Or is it just only GPS, because at this somebody based up in the Highlands, but yeah.

**RA:** Yeah, no anyone, yeah anyone can refer and the most the most common source of referrals is GP's. But yeah, anyone can refer.

**MK:** Or self-refer. Certainly, I think most places would take self-referrals as well.

**GW**: OK, that's good to know and in terms of for patients who perhaps English isn't their first language, is that you use interpreters or the translation service available or?

**RA:** Yeah, so what we've found is worked best actually. Is having the desk phone in the in-practice room on speakerphone and having the language line interpretation services and it takes I've done about. A dozen appointments now with in various different languages, and it's quite off putting the first time that you do get used to it with a 50-minute listening appointment and it's you do get into the swing of.

They're only being two people in the room and having a third person extremely professional and completely blown away by the interpretation services skills, but it does. It does take a while- it's getting into the swing of it. But yeah, absolutely. It's absolutely there for people who need it. Yeah. Yeah.

OK, that's helpful. Thank you.

**GW**: And another question here for somebody potentially interested in almost setting up some services and they maybe don't have them at the moment, but they're saying if we were wanting to establish some listening services, what would be the key selling points for a GP practice and how would we best identify which areas would benefit most from this?

**RA:** So, I don't know who that question is from and whether or not that's from someone who works for a spiritual care department or not, but I would definitely encourage somebody to have a conversation first with the Department of Spiritual Care, because this is a core part of spiritual care kind of strategy is the community, the Community listening part of it? So have a chat with them. Come and have a chat with us as well, so we've there's between various different people in Scotland. There's a huge amount of experience of setting up CCL services from scratch in practices that have never had it before. And the types of conversations you might have with, uh, with GP practices in order to set that service up. But to be honest. In Tayside, I mean it doesn't cost the practices anything and to have the service in their practice it is in Tayside. I'm funded and a colleague or a full time permanently funded by the Health and Social Care partnerships across Tayside jointly. So, it doesn't cost the practices anything. So, in all honesty we get our hands bitten off by GP practices wanting the service and their practice. So, there shouldn't be it. That's the main issue is not selling it to the practices. The main issue is finding that core support to be able to support the team of listeners and to develop the service as it needs to develop and to make sure all that support, and training is in place for people. So yeah, there's various different ways of accessing that type of that type of resource.

So yeah, any other conversations around that? Happy to have one to ones or point you in the direction of the local department.

**GW:** No, that's helpful Rebecca

**MK:** The problems that we have certainly in Grampian with the GP practices in particular, is space. They really do want the service, but they haven't got a room for us. So that that's our challenge for us to be looking at how we can get around that one.

**GW**: OK. And is there a limit to the number of sessions that are offered as a kind of fixed program? Initially someone was asking.

**RA:** yeah so. It's been interesting, a lot of it is. Is entirely decided by the person who uses the service, so a lot of people will only need or only feel that they need one or two appointments. They might come into the service expecting to have to need weekly appointments that go on for weeks or months, but actually that 50-minute space just to offload to explain to describe, is enough for what they're looking for. And then they the security to know that they can come back and make further

appointments is always there if we do on the occasion that we do get up to in Tayside. This is the way we work and if they do get up to about five or six appointments and there might be a little bit of review with the person to see how they're feeling, how things are going, it might be that there's more specific forms of support out there, more specialist forms of support in the community. For example, it might be Women's Aid. It might be, you know, welfare rights support could be anything that might be a bit more specialist around what it is that they're bringing to a CCL session. But what we do say to people is that we're not intended to be a long-term source of support and. And the other thing is, if? If somebody's main challenge that they're having is social isolation, so they're really looking for solid social support over a long period of time, that's not what we're able to offer. There are fantastic befriending services out there in the community, and also the other thing to highlight is actually social prescribing and the loneliness that can be generated by bereavement can be overwhelming for people, and so don't forget that you should all have local social prescribing services and link workers who when the time is right for that person can help them to access other kind of more sustainable forms of community support. So don't forget your social prescribers. Either. They're also brilliant listeners, but they have a huge range of services and tools at the fingertips as well.

**MK:** Yeah, I think we do encourage people when they're doing the training to build up their own resources.

The link workers are great and there is great source of referral, but there can be a very informal kind of bank of stuff. I mean I've got loads of things I can refer people to, like lunch clubs and book groups and websites and things like that. I think we all build up our own resources for that.

**GW:** And I suppose there's a question here. Can I link to delivering the service there? But in terms of if someone's asking if space is an issue, has there been experience of delivering the services online either? Over even over the telephone or any kind of virtual online delivery, does that happen?

**RA:** Yes, so it's actually it's really interesting when so I started my job here in Tayside in February 2020 and within eight weeks we had switched everything over to the phone. I was, you know, fully expecting it to be all. It'll just be a few weeks. It'll be fine. And then we'll be back into the practices. And two years later, we still have an amazing kind of team of people who do central phone appointments because a lot of people actually might prefer using the phone to be turning up to GP practice. Interesting, there was speaking to a colleague, and we were saying how it's interesting that some men seem to prefer using the phone because there maybe isn't that sense of. If that feeling of judgment of sitting in front of somebody while you're telling you know you're telling your story, but having that sense of anonymity, that the phone kind of provides has been beneficial to people as well. So yeah, absolutely has provided the phone. We considered providing it via teams or zoom, or near me or attend anywhere. But we carefully looked at the setting of that up because a lot of our listeners are volunteers as they don't have access to IT systems, but also. That looks at similar services and what the take up of face of video conferencing appointments wasn't? It was a very low take up in comparison to phone, so we just decided not to go down that route in Tayside. I know others have tried to do the near me service in some places but yeah, we decided to […]

**MK:** I mean the service, it was very dependent on the surgeries and whether they suggested that or not. But it was interesting because although a lot of people were offered the near me service, the take up wasn't great. It was mostly phone and. So yeah, we do. We do deliver by phone, but I think most of us would say would prefer not to. And that's in Aberdeen.

**GW:** Yeah and Sarah maybe you wanted to add about that in terms of maybe providing, but even support either through kind of virtually near me type service or telephones during the pandemic. From the sound GP perspective.

**SL:** I think there's so much lost in the subtleness and you know, we're now. Very experienced with telephone consulting in a way that we weren't before but. They are they going to see something else as though that there's we. We lose a lot, and we were exactly the same near me. We went to near me, and video consulting and we had very, very limited uptake still do two consultations a day with near me, but they're very planned. Kind of medicine reviews, sort of. Quite straightforward medicine and it just feels a little bit less human, a little bit less connected to do it in that way, and certainly not opportunistically. You know, we're faster to see somebody face to face to face in primary care. You can do a consultation within your 10-minute slot face to face and on average your telephone consultations. There's a little bit longer and our video consultations are shorter. And so, it's. And that's with my quality improvement hat on. We've timed ten of these things, and I think we're fastest and most connected face to face. And for something like this, you can get away with a lot.

And with a touch of the arm and a nod and a reassurance that you could never do on video, so yeah.

**GW:** No thank you for that. Just checking that any final questions, I think them again just about the availability of CCL. Someone asked if available within Edinburgh and the Lothian area. I don't know if you're able to answer that one.

**RA:** It's very limited in Lothian at the moment, but definitely I would contact the local spiritual care department. They'll be able to give you an update on whether or not they're going to be expanding and training more people.

**GW:** OK, thanks for that. Looking it doesn't look like there's any further questions or sort of coming up towards the end of our time. I mean, I suppose one thing that struck my VMS was the there's been lots of useful advice as opposed to you in terms of how we can support people and even say it was talking about the, that referral that you made to the acute admissions unit to and the different approach that had just from that little bit extra in their referals. And that's how. Is there ways we can kind of try and embrace this culture and train people that are coming through in terms of how they should do that? I don't know if there's any comments and how we raise that awareness of the importance of bereavement or create those bereavement friendly workplaces that people feel able to sort of deliver care this way I don't know anything final comments from any of you.

**SL:** I certainly I feel like I've aged into this. And I think that's probably my own life and my own lived experience. I think as a junior doctor. And the new partner I was, I was just so much more efficient, but maybe a little bit less compassionate, and I think I think mentoring and mirroring people, seeing it as they come through. And this is probably beneficial. But it's the experience too.

**RA**: Yeah. I would say don't lose confidence in your own abilities to be able to provide that care, and it can be daunting, but do trust. Trust your own abilities to provide that kind of listening. Support people at any point. It doesn't even need to be about bereavement it can be at any point. If you feel as though you've run out of tools in your clinical tools in your box, there's always listening in that box, so and it does, it does work. It really does work because I do trust your own abilities to do that.

**VW:** I think my one thing is Graham has been a bit vulnerable yourself and being a bit open and honest and transparent and just saying I'm really struggling this week. I've have had some a family bereavement and just growing that culture and breeding that culture because ten years ago I would have gone into work and not told someone that a close family member had died or something

whereas now I'm telling people like probably just I've experienced so much grief during Covid and so much death. I'm just like you know I'm going to talk about this. I'm going to talk about this and the more I am I can see people. Mirroring, my behaviour as well, yeah.

**GW:** No, absolutely I have been produced a lot of film during the at the beginning of the pandemic could just bring talk, has, you know, tell people how you're feeling. Ask them, listen, and just be kind. That's where the basis of that, but. Well, that's just coming up to 1:30, so just want to say a huge thanks to all four of you. I think there's what's the nice comments in the in the box of it, the very compassionate stories, and it's been lovely to hear your experiences. So, thank you very much for your contributions today, and we'll see if people can fill in the feedback when they're available, which we list up there or some of the, the previous webinars that that are available, and we've also got our bereavement conference coming up at the end of this year in the 24th of November.

So that's a date for peoples diaries. But further webinar will be information will be available on the on the website as we deliver them. So, thanks again and wish everybody a nice afternoon. Bye.